P.O. BOX 2080, MECHANICSBURG PA 17055-0787
800 445-1212 **T** 717 796-8080 **F** PMSLIC.com

APPLICATION FOR PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE

Please complete the entire application. Indicate not applicable (n/a) where appropriate.

Producer Name

PART I NAME AND ADDRESS

First Name ______ Middle Name ______ Last Name ______ ☐ MD ☐ DO

☐ Male ☐ Female ______ Date of Birth ______ Pennsylvania Medical License Number (Mandatory)

Mailing/Billing Address ______ City ______ State ______ Zip Code

Home Address ______ City ______ State ______ Zip Code

Office Telephone (*including area code*) ______ Home Telephone (*including area code*) ______ FAX (*including area code*)

Business Manager/Administrator ______ E-mail ______ Web Site

PART II COVERAGE INFORMATION — PROVIDE A COPY OF YOUR DECLARATIONS PAGE FROM YOUR MOST RECENT INSURANCE POLICY.

A. Coverage Desired

- ☐ Claims-made without prior acts coverage. Under this option the retroactive date will be the same as the effective date of coverage.
- ☐ Claims-made with prior acts coverage. Under this option the retroactive date will be the same as the retroactive date on your current policy.

Requested effective date 12:01 a.m. ______ Retroactive Date ______

NOTE: If you are moving to Pennsylvania you must purchase "tail" (retroactive reporting) coverage from your present carrier unless your existing coverage is on an occurrence basis.

B. Previous Professional Liability Insurers

List all previous professional liability insurance you have had for the past five years, beginning with the most current.

1. ______ Insurer ☐ Occurrence ☐ Claims-made ______ mm/dd/yyyy to ______ mm/dd/yyyy
2. ______ Insurer ☐ Occurrence ☐ Claims-made ______ mm/dd/yyyy to ______ mm/dd/yyyy
3. ______ Insurer ☐ Occurrence ☐ Claims-made ______ mm/dd/yyyy to ______ mm/dd/yyyy

Have you changed medical specialties within the last three years? ☐ **YES** ☐ **NO**

If **YES**, list the specialty change, practice hours and dates:

	MEDICAL SPECIALTY	NO. HOURS/WEEK	FROM	TO
1.				
2.				

C. Indicate average weekly practice hours for which PMSLIC insurance is desired: ______ hour(s)/week

D. Will you also carry insurance with another company? ☐ **YES** ☐ **NO** If **YES**, please provide details.

PART III CLAIMS INFORMATION

Do you have any open/pending malpractice claims or suits filed against you? .... ☐ YES ☐ NO

Have you had any malpractice claims or suits filed against you, settled, dismissed or discontinued? .... ☐ YES ☐ NO

If **YES** to either question above, please complete a Claims Information Supplement.

PART IV MEDICAL EDUCATION/BACKGROUND — COMPLETE THE FOLLOWING AND PROVIDE A COPY OF YOUR CV

A. What is your medical specialty? ______________ Percent of Practice ______________

Other/sub-specialty? ______________ Percent of Practice ______________

B. Are you board certified? ☐ **YES** ☐ **NO**
If **YES**, list board certifications and date certified

CERTIFICATION	DATE CERTIFIED (M/Y)
1.	
2.	
3.	

C. Medical School Name ______________ Year graduated ______________

Degree ______________

D. Internship Location (Name of Hospital) ______________

From ______ To ______ Type ______________

E. Residency Location(s)

1. Name of Hospital ______________

From ______ To ______ Type ______________

2. Name of Hospital ______________

From ______ To ______ Type ______________

F. Additional Training/Fellowship (Name of Hospital) ______________

From ______ To ______ Type ______________

PART V MEDICAL PROCEDURES — Check any of the following applicable to your practice

- ☐ No Surgery (*see definition on following page*)
- ☐ Minor Surgery (*see definition on following page*)
- ☐ Major Surgery (*see definition on following page*)
- ☐ Biopsy Type: ______________
- ☐ Endoscopic Procedures Other than Sigmoidoscopy
- ☐ Pre-Natal Care
- ☐ Pain Management
- ☐ Workers Compensation Patients ______ %
- ☐ Permanent Spinal Cord Stimulator Implants
- ☐ Non-Invasive Cardiology
- ☐ Invasive/Interventional Cardiology
- ☐ Cosmetic Skin Flaps/Grafts
- ☐ Chemical Peels - Deep
- ☐ Normal Deliveries
- ☐ C-Sections
- ☐ Bariatric Surgery
- ☐ Assist in Major Surgery on Own Patients
- ☐ Assist in Major Surgery on Other than Own Patients
- ☐ ER - More than 8 Hours Per Week
- ☐ Prison - More than 8 Hours Per Week
- ☐ Reading/Interpreting of Radiology Films/Studies
- ☐ Interventional Radiology
- ☐ Angiography
- ☐ Angioplasty
- ☐ Laser Surgery/Therapy Type: ______________
- ☐ Liposuction/Lipoinjection
- ☐ Hair Transplants - Scalp Exisions/Transplantations
- ☐ Diagnostic D&Cs
- ☐ Tubal Ligations

***No Surgery*—**Applies to family or general practitioners and other specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), and who do not assist other physicians during the performance of surgical procedures.

***Minor Surgery*—**Applies to family or general practitioners and other specialists who perform minor surgery, who perform extra-hazardous medical techniques as determined by the Company or who assist in major surgery on their own patients.

***Major Surgery*—**Applies to family or general practitioners and other specialists who perform major surgical procedures or who assist in majory surgery on other than their own patients. T & As, cesarean sections, abortions, heart catheterizations, obstetrical deliveries, vasectomies on other than the physician's own patients and other procedures determined by the Company are considered major surgery.

PART VI PRACTICE AND HOSPITAL LOCATIONS — percentages must total 100%.
NOTE: Please base percentage of practice on the number of patients treated.

A. PRACTICE LOCATIONS — LIST PRINCIPAL LOCATION FIRST

1. ____
Suite Number and Street

______________________ ____________ ____________
City State Zip Code

______________________ ____________
County % of Practice

2. ____
Suite Number and Street

______________________ ____________ ____________
City State Zip Code

______________________ ____________
County % of Practice

3. ____
Suite Number and Street

______________________ ____________ ____________
City State Zip Code

______________________ ____________
County % of Practice

B. HOSPITAL LOCATIONS — Do you have hospital staff privileges? ☐ **YES** ☐ **NO** If **YES**, please indicate below:

1. ______________________ ____________
Hospital Name City

______________________ ____________
State County

______________________ ____________
Type of Privileges % of Practice

2. ______________________ ____________
Hospital Name City

______________________ ____________
State County

______________________ ____________
Type of Privileges % of Practice

3. ______________________ ____________
Hospital Name City

______________________ ____________
State County

______________________ ____________
Type of Privileges % of Practice

C. Will you practice out of state subsequent to the requested date of coverage? ☐ **YES** ☐ **NO**

If yes, state(s) ______________________ Percent of Practice ____________

PART VII PRACTICE ORGANIZATION

- ☐ Solo Unincorporated
- ☐ Solo Corporation
- ☐ Employee
- ☐ Partner of Partnership
- ☐ Independent Contractor
- ☐ Corporate Shareholder

A. Name of corporation, partnership or employer ______________________________

B. Do you wish coverage for your professional corporation or partnership: ☐ **YES** ☐ **NO**
If **YES**, a separate corporation/partnership application is needed (*complete one application per entity*).

C. Do you use an unincorporated trade name (DBA)? ☐ **YES** ☐ **NO**

If **YES**, please provide the name: ______________________________

D. Do you **employ** other physicians/surgeons (non-shareholders/partners)? ☐ **YES** ☐ **NO**
If **YES**, please provide a list of names and specialties.

NAME	SPECIALTY

E. Healthcare Extender Coverage

☐ Employee Shared Limits and Liability Endorsement
This coverage extends liability limits of $500,000/$1,000,000 to employees of the policyholder at no additional premium. The limit of liability is a shared limit among the employees and is separate from the policyholder's limit of liability.
Coverage under this endorsement does not include physicians, nurse midwives, certified nurse anesthetists, physician assistants, nurse practitioners, surgical assistants, optometrists, dentists or podiatrists.

☐ Designated Employee Coverage
This coverage is available to those non-physician healthcare extenders not included under the employee shared limit of liability. If you wish to apply for coverage for any such employed non-physician healthcare extender, please complete a Designated Employee Application for each individual.

PART VIII ADDITIONAL INFORMATION

A. During the past year, have you incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical specialty? If **YES**, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. .... ☐ **YES** ☐ **NO**

B. Have you been charged or convicted of any crime other than minor traffic violations? If **YES**, provide details below........ ☐ **YES** ☐ **NO**

C. Have you had your privileges or license either voluntarily or involuntarily revoked, suspended, restricted, subject to a reprimand, placed on probation? If **YES**, provide details below .... ☐ **YES** ☐ **NO**

D. Has any insurer ever cancelled, declined, refused to renew or only accepted on special terms your professional liability insurance? If **YES**, provide details below. .... ☐ **YES** ☐ **NO**

Use this space to provide additional information that would be helpful in reviewing your application for insurance.

1. I hereby declare that, to the best of my knowledge and belief, all the statements in this application, including any supplemental materials, are true and correct and I have not knowingly withheld any information which is calculated to influence the judgment of PMSLIC in considering this application for professional liability insurance. I understand that any material misrepresentation in this application which PMSLIC relies on to its detriment shall void coverage.

2. I hereby authorize PMSLIC to obtain full information from any person or insurance companies with respect to any claim or suit pertaining to professional acts or omissions asserted against me. I further authorize and consent to the release of information by a hospital/facility, its medical staff, medical associations or licensure board on request regarding any information they may have concerning my staff privileges and/or licensure.

3. I understand that this application is subject to acceptance by PMSLIC and does not bind coverage.

_______________________________________ _______________________

Signature of Applicant Date

PLEASE DATE AND SIGN ABOVE AND RETAIN A COPY OF THIS APPLICATION FOR YOUR FILES.

Pennsylvania law requires that we notify you of the following:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.